

**WISCONSIN MEDICAID**  
**PRIOR AUTHORIZATION / DENTAL ATTACHMENT 2 (PA/DA2)**  
**ORAL SURGERY, ORTHODONTIC, AND FIXED PROSTHETIC SERVICES**

**INSTRUCTIONS:** Complete Section I for all orthodontics, oral surgery, and fixed prosthetic services. Complete Section II when anesthesia or a professional visit is necessary. Complete Section III for orthodontic services only. Requested identifying information will only be used to process the prior authorization (PA) request. If necessary, attach additional pages for provider responses. **Refer to the Dental Services Handbook and Wisconsin Medicaid and BadgerCare Updates for service restrictions and additional documentation requirements.** Provide enough information for Wisconsin Medicaid dental consultants to make a reasonable judgement about the request. The use of this form is voluntary and providers may develop their own form as long as it includes all the information and is formatted exactly like this form.

Prior Authorization Dental Request Form (PA/DRF) Number	Recipient's Medicaid Identification Number	Billing Provider Medicaid Provider Number	Performing Provider Medicaid Provider Number
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**SECTION I — ORAL SURGERY, ORTHODONTIC, AND FIXED PROSTHETIC SERVICES**

1. Diagnosis

2. Treatment plan

3. Treatment prognosis (Check one. If Poor, explain the reason for requested treatment.)

☐ Excellent    ☐ Good    ☐ Fair    ☐ Poor

4. Indicate if the recipient is physically, psychologically, or otherwise indefinitely disabled, or has a medical condition that impacts the treatment requested

**SECTION II — ANESTHESIA / PROFESSIONAL VISIT**

5. PROCEDURE CODES (CHECK ALL THAT APPLY)	6. TREATMENT PLAN JUSTIFICATION (CHECK ALL THAT APPLY)	7. REQUIRED DOCUMENTATION
<input type="checkbox"/> D9220 <input type="checkbox"/> D9241 <input type="checkbox"/> D9248 <input type="checkbox"/> D9420	<input type="checkbox"/> Behavior <input type="checkbox"/> Disability (describe) _____ <input type="checkbox"/> Geriatric <input type="checkbox"/> Physician consult <input type="checkbox"/> Complicated medical history _____ <input type="checkbox"/> Extensive restoration <input type="checkbox"/> Maxillofacial surgery (describe) _____	<ul style="list-style-type: none"><li>• Submit medical documentation to support special circumstances.</li><li>• Prior authorization not required for recipients five years and under for procedure D9420.</li></ul>

**SECTION III — ORTHODONTIC SERVICES ONLY**

8. Anticipated number of monthly adjustments

### **Submitting Prior Authorization Requests**

Dentists may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616 **if X-rays or models are not required for documentation purposes**. Dentists who wish to continue submitting PA requests by mail or who are submitting PA requests that require X-rays or models may do so by submitting them to the following address:

Wisconsin Medicaid  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for dental services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior PA requests, or processing provider claims for reimbursement. The Prior Authorization/Dental Attachment 2 (PA/DA2) is mandatory when requesting PA for fixed prosthetic services, oral surgery services, and orthodontic services. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.